Ontario

Ministry of Health and Long-Term Care

Inspection Report under the Long-Term Care Homes Act, 2007

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection sous la Loi de 2007 sur les foyers de soins de longue durée

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

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Report Date(s) / Date(s) du Rapport	Inspection No / No de l'inspection	Log # / Registre no	Type of Inspection / Genre d'inspection
Oct 21, 2014	2014_322156_0014	H-000828-14	Complaint

Licensee/Titulaire de permis

REVERA LONG TERM CARE INC.
55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2

Long-Term Care Home/Foyer de soins de longue durée

BRIERWOOD GARDENS
425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

CAROL POLCZ (156)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Complaint inspection.

This inspection was conducted on the following date(s): September 24, 25, 2014

This inspection was in relation to H-000828-14

During the course of the inspection, the inspector(s) spoke with Administrator, Director of Care, registered staff, personal support workers, dietary aides, cooks, residents and families

During the course of the inspection, the inspector(s) observed meal service and food production, reviewed resident clinical records, and policies and procedures

The following Inspection Protocols were used during this inspection:

Dining Observation
Nutrition and Hydration

Findings of Non-Compliance were found during this inspection.

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (A requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA.) The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA.	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (Une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD.

WN #1: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 6. Plan of care

Specifically failed to comply with the following:

s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

s. 6. (10) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time when,
(a) a goal in the plan is met; 2007, c. 8, s. 6 (10).
(b) the resident's care needs change or care set out in the plan is no longer necessary; or 2007, c. 8, s. 6 (10).
(c) care set out in the plan has not been effective. 2007, c. 8, s. 6 (10).

Findings/Faits saillants :

1. The licensee failed to ensure that care set out in the plan of care was provided to the resident as specified in the plan.
a)The plan of care for resident #5 indicated that the resident was deemed at high nutritional risk due to factors included on a therapeutic diet. The plan of care indicated that the resident was to avoid certain foods however, during the observed lunch meal on September 25, 2014, the resident was provided with one of the food items.
b)The plan of care for resident #4 indicated that the resident was deemed at high nutritional risk due to factors included on a therapeutic diet. The plan of care indicated that the resident was to avoid certain foods however, during the observed lunch meal on September 25, 2014, the resident was provided with one of the food items. [s. 6. (7)]

2. The licensee failed to ensure that the resident was reassessed and the plan of care reviewed and revised when the resident's care needs change or care set out in the plan is no longer necessary. The plan of care for resident #2 indicated that the resident was independent to eat on their own, however, staff confirmed on September 25, 2014 that the resident had a change in condition and now required total assistance in eating. The resident was observed for three meals on September 24 and 25, 2014 and required total feeding assistance. The resident was not reassessed and plan of care was not revised when the resident's care needs changed. [s. 6. (10) (b)]

Additional Required Actions:

CO # - 001 will be served on the licensee. Refer to the "Order(s) of the Inspector".
VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance in relation to ensuring care is provided as specified in the plan, to be implemented voluntarily.

WN #2: The Licensee has failed to comply with O.Reg 79/10, s. 8. Policies, etc., to be followed, and records

Specifically failed to comply with the following:

s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and O. Reg. 79/10, s. 8 (1).
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Findings/Faits saillants :

1. The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place is complied with. The home policy LTC-G-30 Food and Fluid Intake Monitoring revised March 2014 indicated that a referral to the RD would be initiated if a resident's fluid intake as recorded was less than the recommended minimum intake for three consecutive days.
a)Resident #1 had their hydration requirements assessed at requiring a minimum of 1700 ml/day. During the month of July, the resident did not meet their hydration needs for twelve consecutive days from July 9-20, 2014 and again for ten consecutive days from July 21-31, 2014. A referral to the RD was not initiated although the resident's fluid intake was less than the recommended minimum intake for more than three consecutive days. This was confirmed with the ADOC during interview on September 25, 2014.
b)Resident #3 had their hydration requirements assessed at requiring a minimum of 1400 ml/day. During the month of July, the resident did not meet their hydration needs on all days except for two. The resident did not meet their hydration needs on five consecutive days from July 1-5, 2014 and again on six consecutive days from July 7-12, 2014 and on eighteen consecutive days from July 14-31, 2014. A referral to the RD was not initiated although the resident's fluid intake was less than the recommended minimum intake for more than three consecutive days. This was confirmed with the ADOC during interview on September 25, 2014. [s. 8. (1) (a),s. 8. (1) (b)]

Additional Required Actions:

CO # - 002 will be served on the licensee. Refer to the "Order(s) of the Inspector".

WN #3: The Licensee has failed to comply with O.Reg 79/10, s. 73. Dining and snack service

Specifically failed to comply with the following:

s. 73. (2) The licensee shall ensure that,
(a) no person simultaneously assists more than two residents who need total assistance with eating or drinking; and O. Reg. 79/10, s. 73 (2).

s. 73. (2) The licensee shall ensure that,
(b) no resident who requires assistance with eating or drinking is served a meal until someone is available to provide the assistance required by the resident. O. Reg. 79/10, s. 73 (2).

Findings/Faits saillants :

1. The licensee has failed to ensure that staff members assist only one or two residents at the same time who need total assistance with eating or drinking. During the observed dinner meal on September 25, 2014, a staff member was observed feeding three residents at the same time. The plan of care for resident #10 indicated that the resident required extensive to total assistance at all meals. The plan of care for resident #12 indicated that the resident required support for eating and verbal cueing but on the observed day, the resident required total assistance. The plan for resident #7 required total assistance in eating. These three residents were provided assistance from one staff member during the dinner meal on September 25, 2014. [s. 73. (2) (a)]

2. The licensee has failed to ensure that residents who require assistance with eating or drinking only served a meal when someone is available to provide the assistance.
a) The plan of care for resident #7 indicated that the resident required total assistance with meals. During the observed dinner meal on September 25, 2014, the meal was on the table at 1715 hours but the resident was not provided assistance in eating until 1725 hours. Dessert was served and on the table in front of the resident at 1740 hours, however, assistance in eating was not provided to the resident until 1750 hours.
b) The plan of care for resident #2 indicated that the resident was independent to eat on their own, however, staff confirmed on September 25, 2014 that the resident now required total assistance in eating. During the observed dinner meal on September 25, 2014, the meal was on the table at 1715 hours but the resident was not provided assistance in eating until 1725 hours.
c) The plan of care for resident #6 indicated that the resident was totally dependent on others for feeding. During the observed dinner meal on September 25, 2014, the meal was on the table at 1715 hours. The resident was not provided assistance in

eating until 1723 hours when the resident was fed a few bites. The HCA left the table to perform other tasks and did not return to assist the resident until 1745 hours.
d) The plan of care for resident #9 indicated that the resident was independent in eating, however, required support. During the observed dinner meal on September 25, 2014, the meal was on the table and the resident was observed asleep at the table at 1730 hours. The resident was not provided any support or encouragement in eating until 1750 hours.
e) The plan of care for resident #8 indicated that the resident required assistance in eating and prompting to remain alert during mealtime. During the observed dinner meal on September 25, 2014, the meal was on the table at 1730 hours and the resident was observed to be asleep at the table. The resident was not provided assistance or encouragement in eating until 1745 hours. [s. 73. (2) (b)]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance to ensure that staff members only assist one or two residents at the same time who need total assistance with eating or drinking and that residents who require assistance with eating or drinking are only served a meal when someone is available to provide the assistance, to be implemented voluntarily.

WN #4: The Licensee has failed to comply with LTCHA, 2007 S.O. 2007, c.8, s. 11. Dietary services and hydration

Specifically failed to comply with the following:

s. 11. (1) Every licensee of a long-term care home shall ensure that there is,
(a) an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents; and 2007, c. 8, s. 11. (1).
(b) an organized program of hydration for the home to meet the hydration needs of residents. 2007, c. 8, s. 11. (1).

Findings/Faits saillants :

1. The licensee failed to ensure that there was an organized program of nutrition care and dietary services for the home to meet the daily nutrition needs of the residents. The observed lunch meal on September 25, 2014 appeared to be disorganized and took a long time to complete. The service started at approximately 1200 hours. At 1240 hours, resident #2 had not yet received the soup appetizer. At 1243 hours, the resident's tablemate who was finished the meal stated to the LTC inspector that the resident still had not received soup and that "this was ridiculous" as he was leaving the dining room. At 1230 hours dessert was being served while several residents were just being served their entrees. At 1243 hours the dining room by the kitchen still had 4/8 tables that had not yet received dessert and staff were still serving entrees to the front dining room. At this time, tables 1, 7, and 6 still had not received their entrees. Table 6 was not served their entrees until 1250 hours and Table 7 had not been served yet. One identified resident was going to leave Table 1 just prior to the entrée being served but was redirected by staff. At 1300 hours, sixteen residents were still eating their entree (most of whom just received it). At 1315 hours, Table 16 were served their dessert and tables 19 and 20 were sitting waiting to be shown the dessert prior to ordering. The residents voiced frustration to the inspector. The DOC confirmed during interview on September 25, 2014 that the meal service was very disorganized. [s. 11. (1) (a)]

Issued on this 5th day of November, 2014

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Health System Accountability and Performance Division
Performance Improvement and Compliance Branch

Division de la responsabilisation et de la performance du système de santé
Direction de l'amélioration de la performance et de la conformité

Public Copy/Copie du public

Name of Inspector (ID #) / Nom de l'inspecteur (No) :	CAROL POLCZ (156)
Inspection No. / No de l'inspection :	2014_322156_0014
Log No. / Registre no:	H-000828-14
Type of Inspection / Genre d'inspection:	Complaint
Report Date(s) / Date(s) du Rapport :	Oct 21, 2014
Licensee / Titulaire de permis :	REVERA LONG TERM CARE INC. 55 STANDISH COURT, 8TH FLOOR, MISSISSAUGA, ON, L5R-4B2
LTC Home / Foyer de SLD :	BRIERWOOD GARDENS 425 PARK ROAD NORTH, BRANTFORD, ON, N3R-7G5
Name of Administrator / Nom de l'administratrice ou de l'administrateur :	CATHERINE DONAHUE

To REVERA LONG TERM CARE INC., you are hereby required to comply with the following order(s) by the date(s) set out below:

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

Order # / Ordre no : 001

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0016, CO #004;

Pursuant to / Aux termes de :

LTCHA, 2007 S.O. 2007, c.8, s. 6. (7) The licensee shall ensure that the care set out in the plan of care is provided to the resident as specified in the plan. 2007, c. 8, s. 6 (7).

Order / Ordre :

The licensee shall ensure that the care set out in the plan of care is provided to all residents including residents #5 and #4 as specified in the plan.

Grounds / Motifs :

1. Previously issued as a CO November 2013, March 2014, May 2014, and July 2014.
The licensee failed to ensure that care set out in the plan of care was provided to resident #5 and #as specified in the plan.
The plans of care for residents #5 and #4 were not followed in relation to a therapeutic diet order. (156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

Order # / Ordre no : 002

Order Type / Genre d'ordre : Compliance Orders, s. 153. (1) (a)

Linked to Existing Order / Lien vers ordre existant: 2014_240506_0016, CO #005;

Pursuant to / Aux termes de :

O.Reg 79/10, s. 8. (1) Where the Act or this Regulation requires the licensee of a long-term care home to have, institute or otherwise put in place any plan, policy, protocol, procedure, strategy or system, the licensee is required to ensure that the plan, policy, protocol, procedure, strategy or system,
(a) is in compliance with and is implemented in accordance with applicable requirements under the Act; and
(b) is complied with. O. Reg. 79/10, s. 8 (1).

Order / Ordre :

The licensee shall ensure that the home is complying with their policies related to hydration.

Grounds / Motifs :

1. Previously issued as a VPC May 2014 and CO July 2014.
The licensee has failed to ensure that any plan, policy, protocol, procedure, strategy or system instituted or otherwise put in place was complied with. The home policy LTC-G-30 Food and Fluid Intake Monitoring revised March 2014 indicated that a referral to the RD would be initiated if a resident's fluid intake as recorded was less than the recommended minimum intake for three consecutive days.
Two identified residents did not meet their assessed hydration needs and a referral was not made to the RD for 22 days and thirty days respectively in July, 2014.

(156)

This order must be complied with by / Vous devez vous conformer à cet ordre d'ici le : Nov 14, 2014

Ontario

Ministry of Health and Long-Term Care

Order(s) of the Inspector
Pursuant to section 153 and/or section 154 of the *Long-Term Care Homes Act, 2007,* S.O. 2007, c.8

Ministére de la Santé et des Soins de longue durée

Ordre(s) de l'inspecteur
Aux termes de l'article 153 et/ou de l'article 154 *de la Loi de 2007 sur les foyers de soins de* longue durée, L.O. 2007, chap. 8

REVIEW/APPEAL INFORMATION

TAKE NOTICE:

The Licensee has the right to request a review by the Director of this (these) Order(s) and to request that the Director stay this (these) Order(s) in accordance with section 163 of the Long-Term Care Homes Act, 2007.

The request for review by the Director must be made in writing and be served on the Director within 28 days from the day the order was served on the Licensee.

The written request for review must include,

(a) the portions of the order in respect of which the review is requested;
(b) any submissions that the Licensee wishes the Director to consider; and
(c) an address for services for the Licensee.

The written request for review must be served personally, by registered mail or by fax upon:

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

When service is made by registered mail, it is deemed to be made on the fifth day after the day of mailing and when service is made by fax, it is deemed to be made on the first business day after the day the fax is sent. If the Licensee is not served with written notice of the Director's decision within 28 days of receipt of the Licensee's request for review, this(these) Order(s) is(are) deemed to be confirmed by the Director and the Licensee is deemed to have been served with a copy of that decision on the expiry of the 28 day period.

The Licensee has the right to appeal the Director's decision on a request for review of an Inspector's Order(s) to the Health Services Appeal and Review Board (HSARB) in accordance with section 164 of the Long-Term Care Homes Act, 2007. The HSARB is an independent tribunal not connected with the Ministry. They are established by legislation to review matters concerning health care services. If the Licensee decides to request a hearing, the Licensee must, within 28 days of being served with the notice of the Director's decision, give a written notice of appeal to both:

Health Services Appeal and Review Board and the Director

Attention Registrar
151 Bloor Street West
9th Floor
Toronto, ON M5S 2T5

Director
c/o Appeals Coordinator
Performance Improvement and Compliance Branch
Ministry of Health and Long-Term Care
1075 Bay Street, 11th Floor
TORONTO, ON
M5S-2B1
Fax: 416-327-7603

Upon receipt, the HSARB will acknowledge your notice of appeal and will provide instructions regarding the appeal process. The Licensee may learn more about the HSARB on the website www.hsarb.on.ca.

RENSEIGNEMENTS SUR LE RÉEXAMEN/L'APPEL

PRENDRE AVIS

En vertu de l'article 163 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis peut demander au directeur de réexaminer l'ordre ou les ordres qu'il a donné et d'en suspendre l'exécution.

La demande de réexamen doit être présentée par écrit et est signifiée au directeur dans les 28 jours qui suivent la signification de l'ordre au titulaire de permis.

La demande de réexamen doit contenir ce qui suit :

a) les parties de l'ordre qui font l'objet de la demande de réexamen;
b) les observations que le titulaire de permis souhaite que le directeur examine;
c) l'adresse du titulaire de permis aux fins de signification.

La demande écrite est signifiée en personne ou envoyée par courrier recommandé ou par télécopieur au:

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

Les demandes envoyées par courrier recommandé sont réputées avoir été signifiées le cinquième jour suivant l'envoi et, en cas de transmission par télécopieur, la signification est réputée faite le jour ouvrable suivant l'envoi. Si le titulaire de permis ne reçoit pas d'avis écrit de la décision du directeur dans les 28 jours suivant la signification de la demande de réexamen, l'ordre ou les ordres sont réputés confirmés par le directeur. Dans ce cas, le titulaire de permis est réputé avoir reçu une copie de la décision avant l'expiration du délai de 28 jours.

En vertu de l'article 164 de la Loi de 2007 sur les foyers de soins de longue durée, le titulaire de permis a le droit d'interjeter appel, auprès de la Commission d'appel et de révision des services de santé, de la décision rendue par le directeur au sujet d'une demande de réexamen d'un ordre ou d'ordres donnés par un inspecteur. La Commission est un tribunal indépendant du ministère. Il a été établi en vertu de la loi et il a pour mandat de trancher des litiges concernant les services de santé. Le titulaire de permis qui décide de demander une audience doit, dans les 28 jours qui suivent celui où lui a été signifié l'avis de décision du directeur, faire parvenir un avis d'appel écrit aux deux endroits suivants :

À l'attention du registraire
Commission d'appel et de révision des services de santé
151, rue Bloor Ouest, 9e étage
Toronto (Ontario) M5S 2T5

Directeur
a/s Coordinateur des appels
Direction de l'amélioration de la performance et de la conformité
Ministère de la Santé et des Soins de longue durée
1075, rue Bay, 11e étage
Ontario, ON
M5S-2B1
Fax: 416-327-7603

La Commission accusera réception des avis d'appel et transmettra des instructions sur la façon de procéder pour interjeter appel. Les titulaires de permis peuvent se renseigner sur la Commission d'appel et de révision des services de santé en consultant son site Web, au www.hsarb.on.ca.

Issued on this 21st day of October, 2014

Signature of Inspector /
Signature de l'inspecteur :

Name of Inspector /
Nom de l'inspecteur : CAROL POLCZ

Service Area Office /
Bureau régional de services : Hamilton Service Area Office